Michael J. Maynard, MD
520 East 72nd Street
New York, NY 10021

ASSIGNMENT OF BENEFITS AUTHORIZATION:

INSURED: ______________________ PATIENT: _________________________
POLICY: ________________________ GRP: __________________________

I request that payment of authorized benefits be made on my behalf to:
Michael J. Maynard, M.D.
I understand my signature will authorize payment to be made directly to my physician; it also authorizes release of medical information necessary to pay this claim.

__________________________ __________________
Insured's Signature Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS:

To Whom It May Concern:
I hereby authorize the office of Michael J. Maynard, M.D. to release my medical records.
I request that the medical records be released to:
____

_____________________________ Patient's Signature

NO LITIGATION:

It is understood and agreed that my purpose of requesting examination and treatment is for medical purposes only and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation, except to provide a true and accurate copy of any medical records and X-Rays in the possession and control of the office pursuant to an authorization by the undersigned, upon receipt of payment for copying charges.

______________________________ Patient's Signature